Community Health Center Association of Connecticut

Testimony of Sara LeMaster, MPAP
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SB 355 AA Establishing the 340B Drug Pricing Nondiscrimination Act

Distinguished leadership of the Insurance and Real Estate Committee:

My name is Sara LeMaster and I am the manager of government relations and public policy for the Community Health Center Association of Connecticut. I am submitting this testimony on SB 355 AN ACT ESTABLISHING THE 340B DRUG PRICING NONDISCRIMINATION ACT.

The Community Health Center Association of Connecticut is Connecticut's primary care association, which supports the work of 16 of Connecticut's health centers. Connecticut's health centers collectively serve over 380,000 residents every year and specialize in providing care for traditionally underserved communities. Health centers do not turn people away based on their ability to pay for services, and patients have access to same-day medical, dental, and behavioral health services. Twenty percent of health center patients identify as Black, and 48% identify as Hispanic or Latino. A majority (58%) receive Medicaid benefits[1].

Throughout the COVID-19 pandemic, our health centers have been working diligently to protect our communities and support our public health infrastructure. Health centers have provided over 935,000 COVID tests and fully vaccinated over 395,000 residents since August of 2020[2], all while continuing to provide care for the most vulnerable.

Connecticut's health centers serve residents in every legislative district. They operate over 100 locations throughout Connecticut, employ over 4,000 people[3] and have an estimated economic impact of over $800 million[4].

Health centers and the 340B program

The 340B drug discount program has been in operation since 1992 and has helped hundreds of thousands of Connecticut residents manage their health care by giving them access to low-cost prescription drugs. The 340B program enhances our healthcare safety net by providing access to affordable prescription medication for low-income, uninsured, and underinsured patients. It also enables covered entities like our health centers to expand their services and support the healthcare safety net.

The original purpose of the program was to address the issue of manufacturers reducing voluntary discounts to safety-net providers in the wake of the Medicaid drug rebate statute. These safety-net providers relied heavily on federal financial assistance as well as other sources of community support,

[1] 2021 UDS data
[2] https://www.nachc.org/research-and-data/covid-19-vaccine-testing-data-by-state/
[3] 2021 UDS data
[4] https://www.nachc.org/wp-content/uploads/2020/12/Economic-Impact-Infographic-2.pdf

and the loss of those voluntary discounts posed a real threat to their ability to continue offering services.

Connecticut's health centers serve thousands of patients with chronic illnesses like diabetes, heart disease, hypertension, and other conditions requiring maintenance medications. Without access to low-cost prescription drugs, health center patients will have to make difficult decisions—like whether to buy school supplies for their children, or insulin to treat their diabetes. Because of these financial hardships, patients sometimes ration their prescription drugs, which is very dangerous and can lead to complications from their illness including hospitalization.

Health centers use revenues from the 340B program to cover operational costs and to invest in community health programs that improve patient outcomes. These additional investments help health centers work with their patients to respond to health disparities present in the communities they serve. Examples of these include partnering with local farmers to increase access to fresh fruits and vegetables, helping uninsured patients purchase medications that they could not otherwise afford, care integration, and other services that greatly benefit health center patients and their communities.

There have been two major threats to the 340B program in recent years:

1. Discriminatory contracting

Discriminatory contracting refers to the pattern or practice of third-party payers and pharmacy benefits managers establishing discriminatory contracting terms based solely on 340B eligibility or participation this treatment may include limiting network participation, requiring 340B claims identification, imposing additional fees and reporting requirements, prohibiting mail order services, and redirecting patients which limits patient choice. Often, third parties offer contracts with reimbursement for prescriptions filled with the 340B purchased drugs at a fraction of the reimbursement for the same prescription filled with non-340B purchased drugs. ***As a result of this practice, pharmacy benefits managers are able to divert 340B savings away from health centers and directly to the for-profit corporations that they work for.*** Diverting these funds back to for-profit corporations does not have a direct positive impact on the health care safety net. Health centers often have a lack of options in the situation, and are often forced to sign discriminatory contracts at the risk of forfeiting their savings and the resources they need to support essential primary care services. **Discriminatory contracting limits the capacity of health centers and hinders their ability to reduce health disparities.**

2. Drug manufacturers and contract pharmacies

Over the last two years, drug manufacturers have willfully refused to honor their **statutorily required 340B price** for covered entities where the drug is being shipped to and dispensed by contract pharmacy partners of that covered entity[5]. Connecticut's health centers have over 100 locations throughout the state, and this geographic spread allows health centers to reach deep into the pockets of communities that have limited access to primary care. However, due to the costs of running these locations, most health centers cannot afford to have a pharmacist on staff at each of these sites, and health centers use

5 https://www.340bhealth.org/newsroom/stop340bcuts/#:~:text=14%20drug%20manufacturers%20%E2%80%93%20Eli%20Lilly,at%20community%20pharmacies%20or%20have

contracts with local pharmacies to secure access to prescription drugs for their patients. This practice has allowed health centers to expand access to affordable prescription drugs while enhancing their ability to promote community health. Without these pharmacy contracts, patients would not be able to access low-cost prescription drugs through their health center. **Recent actions by 14 major drug manufacturers have threatened the integrity of the contract pharmacy model.**

While there is currently federal legislation under consideration to protect the contract pharmacy model[6], CHCACT strongly recommends amending this bill to include a provision to codify this.

Why this legislation is important

- This bill prohibits disparate treatment of 340B covered entities by pharmacy benefits managers, which protects health centers and other 340B covered entities.
- The attacks on the 340B program are not sustainable and if allowed to continue, will lead to further reductions in access to funds for our health centers, which will limit our ability to promote community health. Connecticut's health centers are excellent providers of community health and help to reduce our overall health care costs. By protecting the 340B program, we will also protect health centers and the important cost-saving services that they provide to the health care system.
- By lowering how much they must pay for pharmaceuticals, the 340B program enables health centers to make drugs affordable for their low-income uninsured and underinsured patients, and support other key services that expand access to our medically vulnerable patients.
- The current restrictions that the pharmaceutical industry has placed on the 340 B program are shifting funding that would normally go to supporting our communities into the pockets of pharmacy benefits managers.
- The 340 B program is critical to health centers because as small, community-based organizations, health centers lack the market power to negotiate discounts off the sticker price of drugs. Prior to the 340 B program, most health centers were unable to offer affordable pharmaceuticals to their patients.

I'd like to thank the committee for raising this bill and for giving me the opportunity to testify on this important issue.

Sincerely,

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[6] https://www.congress.gov/bill/117th-congress/house-bill/4390/text#:~:text=(1)%20The%20340B%20drug%20pricing,providers%20receive%20under%20the%20program

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Proposed amendment

CHCACT proposes making several changes to the existing bill based on language currently under consideration in California. These changes would add additional protections to this program:

(a) A drug manufacturer shall comply with federal pricing requirements set forth in Section 256b of Title 42 of the United States Code when selling covered drugs to covered entities located in Connecticut, and shall not impose any preconditions, limitations, delays, or other barriers to the purchase of covered drugs.

(b) Arrangements prohibited by subdivision (a) include all of the following:
   a. Implementation of policies or limitations that restrict the ability of covered entities or specified pharmacies to dispense covered drugs, including restrictions on the number or type of locations through which covered drugs may be dispensed by or on behalf of a covered entity.
   b. Conditioning the sale of covered drugs for covered entities on enrollment with third-party vendors or on the sharing of claims information or other data.
   c. Charging covered entities for covered drugs at amounts above the federal ceiling price, including policies that condition discounts on rebate requests.
   d. Interfering with an individual's choice to receive a covered drug from a covered entity or specified pharmacy, whether in person or via direct delivery, mail, or other form of shipment.
   e. Delays in shipping covered drugs compared to drugs that are not discounted.
   f. Retaliation against a covered entity or specified pharmacy based on its exercise of any right or remedy under this article.

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Health centers participating in the 340B program in Connecticut

Health center name	Region
Fair Haven CHC	New Haven
Generations	Willimantic
CHC, Inc.	Middlesex County
UCFS	New London
CHWC of Greater Torrington	Torrington
CIFC of Greater Danbury	Danbury
Family Centers	Greenwich
Optimus	Bridgeport
Charter Oak	Hartford
Wheeler Clinic	Bristol/ Waterbury
Cornell Scott-Hill	New Haven
Community Health Services	Greater Hartford
StayWell	Waterbury
First Choice	Hartford
Southwest	Bridgeport

NATIONAL ASSOCIATION OF Community Health Centers

How 340B Supports Health Center Patients

By lowering how much they must pay for pharmaceuticals, **340B enables health centers (FQHCs) to:**

- Make drugs affordable for their low-income uninsured and underinsured patients, and
- Support other key services that expand access to their medically vulnerable patients.

Health centers are a tiny part of the total 340B program – accounting for only 6% of national 340B sales. But 340B is critical to health centers' ability to provide affordable drugs & other services to underserved individuals.

Why is 340B so critical to health centers?

- As small, community-based organizations, health centers lack the market power to negotiate discounts off the sticker price.
- Prior to 340B, most health centers were unable to offer affordable pharmaceuticals to their patients.

How does 340B expand access and generate savings for health centers and their patients?

Say the regular price for a drug is $100, and the 340B price is $70. The health center or its contract pharmacy dispense two bottles of the drug – one to an uninsured patient for whom the sliding fee copay is $20, and the second to a patient with private insurance that reimburses the drug's regular price.

Without 340B				With 340B			
The FQHC loses $80, all due to the sliding fee discount.	*Sliding Fee Patient*			The FQHC loses only $20. Their net cost for the uninsured patient is reduced $50, and they retain $30 savings on the insured patient.	*Sliding Fee Patient*		
	Drug Cost	$100	**FQHC loses $80**		Drug Cost	$70	**FQHC loses $50**
	Sliding Fee	$20			Sliding Fee	$20	
	Net Cost	$80			Net Cost	$50	
	Insured Patient				*Insured Patient*		
	Drug Cost	$100	**FQHC breaks even**		Drug Cost	$70	**FQHC retains $30 savings**
	Insurance Pays	$100			Insurance Pays	$100	
	Net Cost	$0			Net Savings	$30	

How do health centers use the savings generated by 340B?

- Health centers invest *every penny* of 340B savings into activities that expand access to their medically-underserved patients. This is

How are 340B Prices Calculated?

A drug's 340B price is its Average Manufacturer Price (AMP) less:

- ***Mandatory discount:*** *23% for brand-names & 13% for generics,*
- ***Inflation Penalty (if applicable):*** *If the manufacturer increases the drug's sticker price faster than inflation, an additional discount is required. If the price rises fast enough, the total discounts can exceed the AMP. In this case, the 340B price is one penny.*

required by Federal law[7], Federal regulations[8] -- and the health center mission.

- Each health center's patient-run Board decides how to best invest its 340B savings.
  - First, they offset losses on drugs for sliding fee patients (e.g., the $50 loss above.)
  - Remaining savings are used for services that could not otherwise be funded. Common examples include expanded SUD treatment, clinical pharmacy programs, and adult dental services.

[7] Public Health Service Act, Section 330(e)(5)(A) and (D)
[8] 45 Code of Federal Register 75.30

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"Pick-Pocketing" of Health Centers' 340B Savings

The 340B program is designed to provide health centers (FQHCs) with savings that enable them to:

- Make drugs affordable for their low-income uninsured and underinsured patients, and
- Support other key services that expand access to their medically vulnerable patients.

Unfortunately, FQHCs are increasingly being forced to hand over their 340B savings to groups who were never intended to benefit from the program. We call this practice "pick-pocketing."

The 340B statute does not protect health centers from having their 340B savings "pick-pocketed" by PBMs and others – & manufacturers' data demands will lead to even greater losses of their 340B savings.

What is 340B pick-pocketing? Currently, health centers can GET 340B savings – but increasingly, they are unable to KEEP them. This is because third parties have found creative ways to transfer the benefit of the 340B savings from health centers to themselves – in other words, to pick the 340B savings out of health centers' pockets.

How does 340B pick-pocketing occur? It can occur in many different ways. The most common way is for an outside group with whom health centers must do business (e.g., insurers, PBMs) to force them to accept contracts that offer lower reimbursement for drugs simply because they were purchased under 340B. Here are some examples how these discriminatory contracts work:

PBM	Insurer	Contract Pharmacy
A PBM normally pays a pharmacy $100 for Mr. A's heart medicine. However, if they know it was purchased under 340B, they pay only $70. Thus, they "pick-pocket" the health center to get the benefit of the $30 savings.	An insurer refuses to contract with the FQHC for any services (including medical care) unless the FQHC agrees to charge only its Actual Acquisition Cost for drugs. While the insurer normally pays $100 for Mr. B's insulin, if that drug is penny-priced, the PBM pays the FQHC only one penny. Thus the $99.99 in 340B savings intended for the FQHC are "pick-pocketed" by the insurer.	A chain pharmacy refuses to contract with a FQHC unless it can keep a percentage of the 340B savings on each drug (plus its fees.) In the case of Mr. B's penny-priced insulin, if the PBM/insurer pays their regular $100 rate, the chain pharmacy keeps $50, plus dispensing & administration fees.

Is pick-pocketing legal? Nothing in the current statute prohibits pick-pocketing. While HRSA has repeatedly expressed concern over these practices, it lacks the authority to stop them.

Why do health centers allow pick-pocketing? It's a David vs. Goliath situation. As community -based, patient-run organizations, health centers lack the market power to successfully push back on "pick-pocketing" contracts. If health centers refuse the terms offered by the PBMs, insurers, etc., they will lose all the business these groups control.

Will drug manufacturers' recent data demands lead to more pick-pocketing of health centers' 340B savings? Absolutely. Manufacturers want data on 340B drugs dispensed to Medicare and privately-insured patients so they can refuse to pay PBMs rebates on those drugs – rebates that they voluntarily negotiated as marketing incentives. Once PBMs stop receiving these rebates, they will know exactly which drugs were purchased under 340B – and experience clearly shows that they will quickly respond by "pick-pocketing" the health center to make up for the loss. Thus, the manufacturers come out ahead,

the PBMs breaks even (what they lose from the manufacturer they take from the health center) and the health center loses.